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ABSTRACT Freestanding emergency departments (EDs), which offer emergency medical care at sites separate from hospitals, are a rapidly growing alternative to traditional hospital-based EDs. We evaluated state regulations of freestanding EDs and describe their effect on the EDs' location, staffing, and services. As of December 2015, thirty-two states collectively had 400 freestanding EDs. Twenty-one states had regulations that allowed freestanding EDs, and twenty-nine states did not have regulations that applied specifically to such EDs (one state had hospital regulations that precluded them). State policies regarding freestanding EDs varied widely, with no standard requirements for location, staffing patterns, or clinical capabilities. States requiring freestanding EDs to have a certificate of need had fewer of such EDs per capita than states without such a requirement. For patients to better understand the capabilities and costs of freestanding EDs and to be able to choose the most appropriate site of emergency care, consistent state regulation of freestanding EDs is needed.

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Emergency departments (EDs) play a critical role in the US health care system, handling one-fourth of all acute care visits and half of all hospital admissions.¹ The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 recognizes EDs as an important part of the social safety net that provides acute medical care to all patients, regardless of their demographic characteristics or ability to pay.²

Most EDs are located within hospitals, but there has been a rapid growth in the number of freestanding EDs in recent years. The concept of a freestanding ED was introduced in the 1970s as a way to provide emergency care in rural areas whose residents lacked access to an acute care hospital.

The two main types of freestanding EDs—hospital-affiliated and independent—differ in size, reimbursement options, and types of services provided. Hospital-affiliated freestanding EDs

are owned by or affiliated directly with hospitals, which allows for the integration of care between the two facilities; if these freestanding EDs bill under the same National Provider Identifier as the affiliated hospital, they fall under the same Centers for Medicare and Medicaid Services (CMS) rules and regulations as the ED of that hospital. In contrast, independent freestanding EDs have owners that range from a single physician to a group of outside investors, such as private equity firms; tend to be limited in their size and the services they offer, compared to hospital-affiliated freestanding EDs; and are not recognized by CMS as EDs.

Thus, providers at hospital-affiliated freestanding EDs that bill with the hospital's National Provider Identifier can bill Medicare for services with emergency medicine codes and be reimbursed for separate facility fees, while providers at independent freestanding EDs can bill Medicare only for a general office visit—which

leaves the patient with a facility fee that is not covered by Medicare. The distinction between the two types is becoming blurred as smaller independent freestanding EDs affiliate with hospitals, and hospitals open freestanding EDs that look like independent EDs.

The number of freestanding EDs grew from 55 in 1978 to 222 in 2008.^{3,4} That growth has been particularly rapid in several states—most notably Texas, where more than 190 freestanding EDs have opened since 2010.⁵

The rapid growth of freestanding EDs has led to a debate about their role in the health care system. Proponents of these EDs cite their potential to provide high-quality emergency care to people in medically underserved areas, relieve the burden on overwhelmed hospital EDs, and provide convenient services with shorter waits for treatment.⁶ Others have voiced concern that freestanding EDs encourage increased use of emergency services for nonemergency complaints, increase the cost of the health care system, and compete with hospitals for ED services—which ultimately threatens access to services that are mainly provided by only hospital EDs, such as trauma care.³

The general public has certain expectations about the type of medical care that is available at EDs, such as care for trauma, heart attacks, and strokes. However, freestanding EDs might not always provide these services (for example, they might not accept ambulances, and most do not provide trauma services). Complicating this debate are the variations across states in the number and location of freestanding EDs and the regulations concerning them³—variations that persist although the American College of Emergency Physicians has recommended core policies that freestanding EDs should adopt.⁷

Given the rapid growth of freestanding EDs in the United States, it is important to understand how state policies affect these EDs' growth, location, and operation. We performed a policy analysis of state laws and regulations affecting freestanding EDs to characterize the services they are required to offer and their operating, equipment, and staffing requirements. We calculated the proportion of state policies that are aligned with the recommendations of the American College of Emergency Physicians.⁷ Freestanding EDs may be required to have a state certificate of need. Therefore, we also analyzed whether that requirement was related to the number of freestanding EDs in a state.

Study Data And Methods

INVENTORY OF FACILITIES AND STATE REGULATIONS

We gathered lists of licensed freestanding

EDs from state departments of health and other state agencies, and we conducted Internet searches for each state using keywords such as *freestanding*, *satellite*, *emergency department*, and *ED*. The inventory of facilities analyzed in this article was current as of December 2015. As a comparison, we also used the number of hospital EDs listed in the American Hospital Association Annual Survey Database for 2013, the most recent year available at the time of our analysis.

State policies and regulations for freestanding EDs were identified from three sources. First, we contacted state departments of health to determine whether freestanding EDs were required to be licensed and requested the applicable regulations. Second, we searched the departments' websites for individual state regulations for freestanding EDs, using keywords such as *freestanding emergency department*, *satellite emergency department*, *off-campus emergency department*, and *emergency facility*. Third, we searched WestlawNext, an online legal research service, to access state policies not available on the departments' websites and identify regulations that had been amended or repealed in recent years. The WestlawNext search was conducted with the assistance of a lawyer and a legal librarian.

We reviewed statutes and regulations to identify specific features that affected licensing, operating, and staffing requirements. Licensing requirements included license fees, population and distance requirements (described below), and ownership restrictions. Operating requirements included regulations that mirror federal EMTALA requirements for medical screening and stabilization, transfer and transport agreements with other hospitals and emergency medical services, and required medical equipment. Staffing requirements pertained to numbers and hours of staffing by providers and support staff, nurse-to-patient ratios, and certifications and training experience (for example, advanced cardiac life support or pediatric advanced life support).^{8,9} We excluded regulatory requirements that did not directly affect the provision of emergency medical care, such as those related to administrative tasks (for example, medical record maintenance) and nonclinical operating tasks (for example, laundry services and waste disposal).

DATA ANALYSIS We developed a standardized data collection sheet with input from experts in emergency care, health economics, and health policy. The sheet was pilot-tested by two trained reviewers and iteratively revised. All state regulations were reviewed by one of the authors, and a subset of five state policies was also reviewed by a lawyer, with disagreements between the two arbitrated by a senior reviewer.

The rapid growth of freestanding EDs has led to a debate about their role in the health care system.

We calculated the proportion of states with freestanding ED regulations that contained specific licensing, operating, and staffing requirements. We also calculated the proportion of states with at least one freestanding ED that had certain regulations specific to freestanding EDs. We calculated the proportion of state regulations that were in alignment with the recommendations of the American College of Emergency Physicians.⁷ We specifically analyzed the relationship between certificate-of-need requirements for freestanding EDs and the number of freestanding EDs across states.

We calculated the population-adjusted number of freestanding EDs in each state by dividing the state-level totals of such EDs by the national population estimates for the state based on 2014 census population estimates.¹⁰ We then compared the population-adjusted number of freestanding EDs in states with and without a certificate-of-need requirement, using a *t*-test on the equality of means.

LIMITATIONS This study had several limitations. First, some state policies were not accessible through WestlawNext or state departments of health. We consulted with a legal librarian to identify repealed regulations and contacted the departments of health by telephone to gather additional information.

Second, the dynamic nature of laws and the market are such that regulations specific to freestanding EDs and the number of such EDs in each state are constantly changing. To minimize the effect of these changes on our results, we continuously updated our national inventory to reflect market and regulatory changes, with the most recent update occurring in December 2015.

Finally, this study accounted for freestanding ED services required by state regulations, but some freestanding EDs might have provided more services, staff members, and technology than their states required. Further research, such as a survey of current services and equipment offered at freestanding EDs, would help

determine the correlation between minimum state requirements and actual services offered.

Study Results

FREESTANDING EMERGENCY DEPARTMENT INVENTORY We found that there were 400 freestanding EDs in the United States as of December 2015, compared with 4,147 hospital EDs as of 2013 (Exhibit 1). Texas and Ohio had the greatest numbers of freestanding EDs.

Twenty-one states had policies specific to freestanding EDs that were either incorporated into the state's hospital regulations or stated independently (for a list of these states, see online Appendix Exhibit A1).¹¹ Twenty-nine states had no regulations specific to freestanding EDs, but two states, New York and Washington, regulated them case by case. One state, California, indirectly barred freestanding EDs by statute in its hospital regulations.

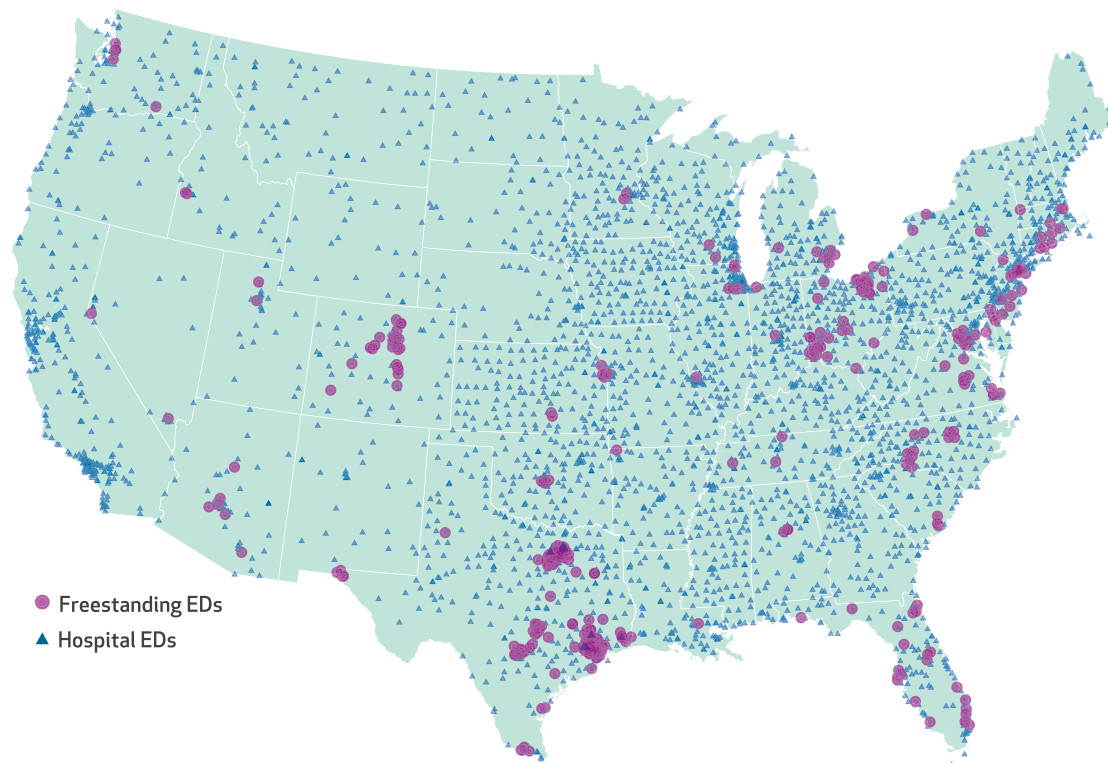
Of the thirty-two states that had freestanding EDs, seventeen had specific policy requirements for them (Appendix Exhibit A1).¹¹ Twenty-three states had hospitals that operated affiliated off-campus EDs, and eleven of these states had policies specific to freestanding EDs that required hospital affiliation. Nine of the thirty-two states with freestanding EDs allowed them to operate independently of accredited hospitals—as indicated by policies specific to freestanding EDs or case-by-case regulation, or by the absence of any policies for freestanding EDs. Four states had regulations for freestanding EDs but did not yet have any freestanding EDs.

STATE REQUIREMENTS FOR FREESTANDING EMERGENCY DEPARTMENTS Twenty-four states required a certificate of need before a freestanding ED could be opened, and twenty-one states required state licensure (Appendix Exhibit A1).¹¹ Of the thirty-two states with freestanding EDs, those with certificate-of-need requirements had significantly fewer of the EDs per capita, compared to states without such a requirement (0.57 versus 1.52 per million people; *p* = 0.03). A significant difference remained even when we excluded Texas from the analysis.

Twenty-two (69 percent) of the thirty-two states with freestanding EDs required them to be integrated into local emergency medical services by having transport agreements with both ambulances and hospitals (twenty-three states require agreements with EMS, and twenty-five require agreements with outside hospitals; Exhibit 2). Exhibit 2 shows the number of states that have policies that were in concordance with the seven American College of Emergency Physicians recommendations for freestanding EDs (Note c); only two (6 percent; data not shown)

EXHIBIT 1

Freestanding and hospital emergency departments in the United States



SOURCE Authors' analysis of data on freestanding EDs gathered as of December 2015; and American Hospital Association Annual Survey Database, 2013.

of the thirty-two states had policies that were in concordance with all seven.⁷ Thirteen (41 percent) of the states had some type of licensing requirements. The median licensing fee was \$2,250, with a range of \$50–\$14,820 (data not shown).

► **GEOGRAPHIC RESTRICTIONS:** Among all states, fourteen (28 percent) had regulations that included requirements for either maximum local population or distance from the nearest hospital, and one state (Illinois) had requirements for both. All fourteen states specified that freestanding EDs be located at least a minimum distance from a hospital—determined by most states in terms of miles, but by some states in terms of presence inside or outside of city or county limits. For example, Mississippi required freestanding EDs to be at least ten miles from any licensed hospital, while Oregon prohibited the opening of a freestanding ED in a county with three or more hospitals that had an ED or in a city with a hospital that had an ED.

► **SERVICES PROVIDED:** EMTALA requires hospital-based EDs to screen all patients for emergency medical conditions, stabilize them, and either provide definitive emergency medical care

or transfer them to another facility that is able to provide such care. EMTALA's provisions apply only to hospitals that have entered into agreements with CMS, not to independent freestanding EDs. Of the thirty-two states with freestanding EDs, twenty-two (69 percent) had requirements for those EDs regarding emergency screening, stabilization, and transfers that mirrored those stipulated by EMTALA; nine (28 percent) of those states had no requirements for provision of these services at a freestanding ED (Exhibit 2).

Many states had regulations requiring that freestanding EDs provide specific medical services; products; and technology such as equipment for monitoring, imaging, and treatment. For example, twelve of the thirty-two states with freestanding EDs required pediatric equipment to be available on site (Exhibit 2). Thirteen states required that the site have a cardiac defibrillator, a device proven to improve survival in cardiac arrest.¹² Nine states required that blood products for transfusion be available on site.

► **STAFFING AND OPERATIONS:** Among the thirty-two states with freestanding EDs, physicians were required to be on site at a freestanding

EXHIBIT 2**State policies for licensing, operating, and staffing freestanding emergency departments (EDs) and requirements for services, 2015**

Policy or regulation	Among 32 states with freestanding EDs:	
	Percent of states with policy or regulation (variable)	Number of states with policy or regulation (outcome)
LICENSING REQUIREMENTS		
State-issued license	41	13
Population requirements ^a	3	1
Distance from hospital or ED ^b	28	9
OPERATING REQUIREMENTS		
Open 24/7 ^c	69	22
Written transfer agreement with outside hospital ^c	78	25
EMS transport agreement	72	23
Ambulance or helipad on site	9	3
Quality improvement program ^c	78	25
EMTALA-LIKE REQUIREMENTS^c		
Screening	69	22
Stabilization	69	22
Transfer	72	23
SERVICES OR PRODUCTS REQUIRED ON SITE		
Cardiac defibrillator	41	13
End tidal carbon dioxidemonitor ^d	13	4
X-ray	47	15
Ultrasound	13	4
Computed tomography	13	4
Blood transfusion products	28	9
Laboratory	44	14
Mechanical ventilation	19	6
Emergency obstetrics kit	22	7
Pediatric equipment	38	12
ON-SITE STAFFING REQUIREMENTS		
Physician		
Available during all hours of operation ^e	47	15
Board certified or eligible for certification in emergency medicine ^c	34	11
Nurse		
Available during all hours of operation ^c	72	23
Certified in ACLS ^c	28	9
Certified in PALS ^c	19	6

SOURCE Authors' analysis of state regulations. **NOTES** EMS is emergency medical services. EMTALA is Emergency Medical Treatment and Labor Act of 1986. ACLS is advanced cardiac life support. PALS is pediatric advanced life support. ^aIllinois requires freestanding EDs to be located in counties with more than 50,000 residents; Georgia requires each county to have no more than one freestanding ED per 35,000 residents. ^bSome states have specific requirements, others only vague ones. Most require a freestanding ED to be within 30–50 miles of a hospital. Nevada requires freestanding EDs to be located more than thirty miles by ground transportation from the nearest emergency department. Other states with distance limits (including three states that do not have freestanding EDs) are AL, GA, ID, IL, LA, MA, MO, NV, NC, ND, OK, and VA. ^cRecommended policies for freestanding EDs by the American College of Emergency Physicians (see Note 7 in text). EMTALA-like requirements, including screening, stabilization, and transfer, are included as one of the seven recommended policies. ^dA device used to monitor ventilation during sedation and airway management. ^eSome states, such as New Hampshire, require physicians to be available within a five-minute driving distance instead of being on site.

ED during all of its hours of operation in fifteen (47 percent) states, and eleven (34 percent) of the states required on-site physicians to be board certified or eligible for certification in emergency medicine (Exhibit 2).¹³ Nurses were required to be on site during all hours of operation in twenty-three (72 percent) of the states.

REGULATIONS IN THREE SELECTED STATES We

analyzed the requirements for freestanding EDs in three states that represent the range of state requirements regarding licensing, screening and stabilization, staffing, and medical equipment. Texas, the state with the most freestanding EDs, had no certificate-of-need requirement or location restrictions, permitted both independent and hospital-affiliated EDs, and had very

specific staffing and equipment requirements (Exhibit 3). In contrast, Alabama, which had only one freestanding ED and strict requirements regarding the location of such EDs, required them to be affiliated with a hospital, but it had few requirements for their staffing and equipment. California required that EDs be part of a hospital and have immediate access to surgical services for life-threatening conditions, effectively banning freestanding EDs. More details on requirements in these and selected other states are available in Appendix Exhibit A2.¹¹

PROJECTIONS FOR GROWTH We next projected the number of freestanding EDs that may open nationwide in the future, based on the EDs' current density in states with and without certificate-of-need requirements. Texas had 7.2 freestanding EDs per million people (data not shown). Projecting that in the future states without those requirements will have the same average density of freestanding EDs as Texas does, we estimated that there may be as many as 1,166 freestanding EDs nationally. The average density of freestanding EDs in the twenty-four states that required a certificate of need was 0.59 ED per one million people. Projecting that all states with that requirement will have the same average den-

sity of freestanding EDs, we estimated that 69 freestanding EDs will open in these states over the next seven years, for a nationwide total of 1,235 freestanding EDs.

If there were a relaxation of certificate-of-need requirements and all states had the same density of freestanding EDs as Texas, we estimated that there could be as many as 2,011 freestanding EDs in the future. This analysis excluded California (where freestanding EDs are essentially banned by state policy) and the District of Columbia. It also did not account for variables other than certificate-of-need requirements, such as political or cultural influences and competition between freestanding EDs and nearby hospitals.

Discussion

ROLE OF FREESTANDING EMERGENCY DEPARTMENTS IN THE HEALTH CARE MARKET The rapid growth in the number of freestanding EDs is changing the delivery of acute medical care in many states. Sources of acute care services now include physician offices, retail clinics, urgent care centers, freestanding EDs, and hospital EDs. None of these settings is strictly defined in terms of the services offered.

However, urgent care centers provide care for

EXHIBIT 3

Variations across three states in policies affecting freestanding emergency departments (EDs), 2015

State (number of freestanding EDs)

Alabama (1)	California (0)	Texas (187)
LICENSING		
License required with annual renewal; CON required. ED must be a satellite of a hospital and located within 35 miles of a hospital.	License from the state Department of Health Care Services required for all health care facilities. Special permit from the department required for any licensee offering basic emergency services. EDs are regulated through hospital regulations only.	License required; CON not required. Additional requirements apply.
SCREENING AND STABILIZATION		
Screening required of all patients for an emergency medical condition, and stabilization or transfer required if the ED does not have the capability to treat such a condition.	No mention of screening or stabilization requirements; no reference to EMTALA in the hospital regulations.	Screening required of all patients for an emergency medical condition, and stabilization or transfer required if the ED does not have the capability to treat such a condition.
STAFFING		
A physician who is board certified or eligible to be certified in emergency medicine is required to be on site during all hours of operation.	A physician who is board certified or eligible to be certified in emergency medicine is required to be on site during all hours of operation.	A physician and a nurse with PALS and ACLS certification must be on site 24/7.
MEDICAL EQUIPMENT		
Radiology and laboratory services are required on site during hours of operation. A helipad is required on site.	Monitoring equipment and laboratory services are required on site 24/7. Surgical services are required to be available immediately for life-threatening situations.	Monitoring equipment is required on site. Radiology services are required 24/7. Both adult and pediatric equipment are specifically required.

SOURCE Authors' analysis of state regulations. **NOTES** CON is certificate of need. EMTALA is Emergency Medical Treatment and Labor Act of 1986. PALS is pediatric advanced life support. ACLS is advanced cardiac life support.

Policy makers should regularly review the services that freestanding EDs are required to provide, as medical practice is dynamic.

a broader range of acute complaints than most physician offices do; are usually staffed by licensed independent providers (physicians, physician assistants, or advanced practice registered nurses), though the providers often lack specific training in emergency medicine; and generally offer only limited laboratory testing and plain (that is, two-dimensional) x-ray services.¹⁴ Freestanding EDs occupy the space in the market between urgent care centers and traditional hospital EDs, providing care for a wide range of acute complaints, being staffed by physicians who often have training in emergency medicine, and providing access to advanced diagnostic testing such as computerized tomography (CT) scans—but not providing the full services of a hospital ED; most do not receive ambulances, do not provide trauma services or specialist consultations, and do not have an operating room on site.³ These characteristics lead to differences in the patient populations receiving care at hospital EDs versus freestanding EDs and to differences in the cost of care at the two types of EDs. Patients treated in freestanding EDs are less severely ill than those treated in hospital EDs, and the cost of providing care is lower in freestanding EDs than in hospital EDs.

Our study demonstrated that state requirements for freestanding EDs range from thorough and well-defined to vague or nonexistent, a range that likely contributes to the wide variation in the services available at freestanding EDs.

Patients may assume that freestanding EDs provide the same services as hospital-based EDs and seek care from a freestanding ED that is not capable of providing them with definitive care—which results in treatment delays that could adversely affect patient outcomes. For example, we found that only twelve of the thirty-two states with freestanding EDs required them to have pediatric equipment available. Previous

research has shown that pediatric equipment and training are needed to provide high-quality care for pediatric emergencies.¹⁵ Parents with sick children often drive them to the nearest ED,¹⁶ which could be a freestanding ED that is not appropriately equipped to provide high-quality pediatric emergency care.

Conversely, patients may assume that freestanding EDs are comparable to urgent care centers or retail clinics and use the EDs for low-acuity complaints, without realizing that the ED facility fee will result in significantly higher total charges for similar services. Newspaper articles¹⁷ and reviews on consumer rating websites¹⁸ have reported examples of this “sticker shock” for freestanding ED services. For example, a patient in Colorado received a bill for \$5,000 for a visit to a freestanding ED at which her two daughters were treated for flu-like symptoms.¹⁷ Similarly, insurers are reporting high bills for freestanding ED visits for low-acuity complaints such as sore throat and earache.¹⁹

INAPPROPRIATE REGULATIONS While a lack of well-defined regulations for freestanding EDs could lead to the problems outlined above, regulations that are overly detailed can also be problematic. For example, state requirements that freestanding EDs provide services or equipment that have not been shown to be critical for high-quality emergency care may increase spending on services that may not be evidence-based, increasing the overall cost of care. Our review of state policies identified several examples of this. Fewer than 2 percent of patients seen at freestanding EDs require transport, and a still smaller share require helicopter transport.²⁰ However, two states required freestanding EDs to have a helipad, although the helicopter is an expensive method of transportation that has not been shown to be cost-effective.²¹

Other state regulations include requirements whose merits are unproven or that are outdated. For example, Mississippi requires freestanding EDs to have supplies for peritoneal lavage, a diagnostic procedure that was abandoned more than ten years ago as the quality of diagnostic imaging improved; and that freestanding EDs carry pneumatic antishock garments, devices for treating shock that are no longer used because of their negative side effects.^{22,23}

Policy makers should regularly review the services that freestanding EDs are required to provide, as medical practice is dynamic. Freestanding EDs should provide services that reflect the current evidence-based standard of care.

IMPACT OF CERTIFICATE-OF-NEED REQUIREMENTS Access to emergency care varies across the United States and within states, with rural areas less likely than urban areas to have EDs,

and urban EDs more likely than rural EDs to be chronically overcrowded and have prolonged waiting times.²⁴ Freestanding EDs have the potential to improve access to emergency care in areas with few other acute care services. However, they can also be duplicative of existing services and increase costs. Certificate-of-need regulations aim to restrain health care costs and restrict development of health care facilities to areas where there is proven need.²⁵

We found that states with certificate-of-need requirements had fewer freestanding EDs per capita than states without such requirements, which indicates that these policies are likely barriers to freestanding ED growth. Previous studies of the effects of these requirements have reported varied results: Some have found that the requirements are associated with more efficient use of hospitals, while others have found that they inhibit competition and can lead to “economic rents” by existing facilities—that is, payments in excess of expected costs because of scarcity or limited availability.²⁶

Certificate-of-need requirements have the potential to be beneficial by limiting growth of freestanding EDs in locations with adequate emergency services and by holding down health care costs. However, they also have the potential to inhibit the growth of freestanding EDs in areas with inadequate emergency care, where the EDs could improve health care quality.

REGULATORY VARIABILITY AND GROWTH From a public health perspective, freestanding EDs have the potential to reshape the safety net that currently guarantees all patients access to emergency care.² But—in contrast to hospital-based EDs and those billing with a hospital National Provider Identifier—-independent freestanding EDs are not bound by the provisions of EMTALA and have no federal obligation to provide emergency care to all patients. Without state-specific regulations addressing this obligation or requiring EMTALA-like protections, the growth of independent freestanding EDs has the potential to create a parallel system of emergency care in which people can be turned away based on their insurance status, age, immigration status, or other factors.

Currently, eighteen of the twenty-one states with regulations for freestanding EDs require them to abide by regulations that mirror those of EMTALA or have similar principles. However, Arizona, Minnesota, and Delaware—with a collective total of ten freestanding EDs—do not. Additionally, hospitals and other providers understand that the government is enforcing the provisions of EMTALA, and that violations carry severe and costly penalties.² In contrast, it is not clear whether state regulations similar to

State policies regulating freestanding EDs have important implications for the delivery and cost of acute care.

EMTALA are being enforced, or whether their penalties are significant enough to prevent non-compliance.

In states with limited regulation of freestanding EDs, the free market is likely to match the supply of the EDs to areas of demand that can be profitable. In a previous study, some of us analyzed where freestanding EDs were located in Colorado, Ohio, and Texas—the three states with the highest numbers of such EDs.²⁷ We found that in Texas and Ohio, neither of which had certificate-of-need requirements, freestanding EDs were located in ZIP codes with a more profitable payer mix and higher incomes. Additionally, in Texas freestanding EDs were located in ZIP codes that had more hospital-based EDs, physician offices, doctor visits, and medical spending per year.

Hospital systems and investor-funded enterprises are rapidly opening new freestanding EDs. For example, Adeptus Health, a publicly traded company, has opened more than seventy-five such EDs and has plans to open many more in states such as Ohio, which allow independent freestanding EDs.^{28,29}

Based on current state laws and regulations, we expect growth in freestanding EDs to be limited to thirty-five states and to be highly concentrated in the twenty-six states without certificate-of-need requirements.³⁰ We also anticipate that the current patchwork of state regulations regarding opening and operating freestanding EDs will lead to an oversupply of them in states with few or no regulations, and fewer of them in states with restrictions or regulations.

Texas and Mississippi illustrate both ends of the spectrum. Texas has no certificate-of-need requirements, less stringent regulations, and large numbers of low-volume freestanding EDs in the suburbs of large cities such as Houston, Dallas, and San Antonio—areas with existing hospital-based EDs.⁵ Conversely, Mississippi, a rural state whose residents have relatively poor

access to emergency care, has a highly complex regulatory structure and only one freestanding ED.

State regulations may change in the face of lobbying efforts from investor-owned companies entering the freestanding ED market or from hospitals fearing competition from a freestanding ED, or because of other concerns about costs associated with freestanding EDs. Commercial operators of freestanding EDs are lobbying for relaxation of certificate-of-need requirements.³¹ Assuming that rates of growth seen in Texas apply nationwide, there could be over 800 more freestanding EDs opening across the United States in the future if there are no regulatory changes, and as many as 1,600 more freestanding EDs opening if there is a relaxation of certificate-of-need requirements.

Policy Implications

Federal law does not define the term *freestanding ED*. Medicare, which imposes requirements on hospital EDs, reimburses only EDs that bill under the National Provider Identifier of a hospital participating in Medicare. Providers at independent freestanding EDs can bill only for a general office visit, which means that the patient is charged for the facility fee. Therefore, while federal regulation can affect the costs and growth of freestanding EDs, it does not dictate how the EDs are structured or the services they offer.

As a result, state policies regulating freestanding EDs have important implications for the delivery and cost of acute care. Efforts to standardize requirements for freestanding EDs' operations across states may help patients choose

the acute care site that is most appropriate for them and avoid unnecessary costs and treatment delays. If states want to ensure that all patients have the right to receive medical care for emergency conditions, those that do not already do so might consider imposing and enforcing EM-TALA-like obligations on freestanding EDs at the state level. Finally, states wishing to restrict the opening of new freestanding EDs to areas of medical need might consider using certificate-of-need requirements or similar regulations.

Conclusion

Freestanding EDs are rapidly changing the landscape of acute care delivery. Overall, freestanding EDs have the potential to improve access to emergency care, but they may also increase health care costs. State regulations will directly affect freestanding EDs' growth, patients' access to them, and the quality of care they provide, and will determine whether their services are aligned with the public perception of emergency care. There is great variation in state requirements regarding the EDs' licensing, operating, and staffing patterns. Certificate-of-need requirements can pose a significant barrier to overall growth of freestanding EDs but may be useful in discouraging their growth in areas that already have adequate access to emergency care. Variations in state policies may lead to an oversupply of freestanding EDs in states with few regulations, with fewer of the EDs operating in states with onerous regulations. As freestanding EDs seek to expand, policy makers can use these findings when considering future regulations concerning them. ■

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NOTES

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